# True Decisions Inc.
**An Independent Review Organization**
**512 W. MLK Blvd., PMB 315**
**Austin, TX 78705**
**Phone: (512) 879-6332**
**Fax: (214) 594-8608**
**Email: rm@truedecisions.com**

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**
May/1/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**
Eighty (80) hours in a chronic pain management program 5 times per week for 2 weeks for back pain

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**
Board Certified PM&R

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[ X ] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

**Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.**

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

**PATIENT CLINICAL HISTORY [SUMMARY]:**
The patient is a male whose date of injury is xx/xx/xx. He experienced a sudden pop in his back and developed acute low back pain and radiating lower extremity pain. The patient underwent lumbar microdiscectomy, laminectomy, foraminotomy and partial facetectomy at L5-S1 on the left on 07/30/13. Follow up note dated 11/23/13 indicates that his pain remains the same. Physical performance evaluation dated 02/03/14 indicates that current PDL is sedentary and required PDL is very heavy. Request for services dated 03/18/14 indicates that the patient has completed a work hardening program. Current medication is Lortab. BDI is 36 and BAI is 32.

Initial request for 80 hours of chronic pain management program was non-certified on 03/25/14 noting that the patient has completed 160 hours of a chronic pain management program and has not really shown much benefit. It is considered doubtful that 2 additional weeks of chronic pain management would provide any additional benefit for this patient who appears to be filling the program. Request for reconsideration dated 04/03/14 indicates that since the patient's completion of a chronic pain management program, he has undergone surgical intervention. The denial was upheld on appeal dated 04/07/14 noting that it appears that the patient has completed both a work hardening program and a prior chronic pain management program. The Official Disability Guidelines do not support reenrollment in or repetition of the same or similar rehabilitation program. Also, per PPE dated 02/03/14, the

patient's current PDL is only sedentary despite these previous programs.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:**
The submitted records indicate that the patient has recently completed a work hardening program. There are no progress notes from this program submitted for review. The Official Disability Guidelines do not support reenrollment in or repetition of the same or similar rehabilitation program and note that chronic pain management program should not be used as a stepping stone after completion of less intensive programs. As such, it is the opinion of the reviewer that the request for eighty hours in a chronic pain management program 5 times per week for 2 weeks for back pain is not recommended as medically necessary.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

**[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

**[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

**[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

**[ ] INTERQUAL CRITERIA**

**[ X ] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

**[ ] MILLIMAN CARE GUIDELINES**

**[ X ] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

**[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

**[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

**[ ] TEXAS TACADA GUIDELINES**

**[ ] TMF SCREENING CRITERIA MANUAL**

**[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

**[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**